Request for Proposals

Vermont State Hospital Futures Project
for
Clinical Design Services for Adult Mental Health Acute and Intensive Care Management System

January 29, 2007

Futures Project
Division of Mental Health
Vermont Department of Health

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OVERVIEW

The Vermont Division of Mental Health, Vermont's single state agency mental health authority, and its host department, the Vermont Department of Health, are seeking proposals to design an adult mental health clinical care management system for acute and intensive services.

During its 2004 session, the Legislature set in motion a strategic planning process for the future of Vermont's public mental health system. The secretary of human services was charged with creating a comprehensive plan for the delivery of services currently provided by the Vermont State Hospital (VSH), within the context of long-range planning for a comprehensive continuum of care for mental health services.

The core of the plan is proposed new investments in the essential community capacities, along with reconfiguration of the existing 54-bed inpatient capacity at the Vermont State Hospital into a new array of inpatient, rehabilitation, and residential services for adults. This plan is consistent with Vermont's long history of establishing strong community support systems and reducing our reliance on institutional care. The fundamental goal is to support recovery for Vermonters with mental illnesses in the least restrictive and most integrated settings.

The Futures Plan, work group reports and other planning documents may be viewed at the Division of Mental Health's web site:

http://healthvermont.gov/mh/update/mhupdate.aspx

The Futures Plan

The Vermont Mental Health Futures Plan calls for the transformation of our service system towards a consumer-directed, trauma-informed, and recovery-oriented system of mental health. When fully implemented, the plan will transform inpatient and recovery services for the most severely ill and will improve coordination of services and increase capacity for all adults with mental illnesses. The result will be a continuum of care in which

- The individual is actively engaged in their own recovery.
- Prevention, early intervention and alternatives to more acute levels of care are pursued aggressively.
- Peer supports are expanded and recognized as essential to recovery.
- All the elements are coordinated.

The Futures Plan envisions the following services components.

New Inpatient Capacity for Intensive Care and Specialized Care

Two new levels of inpatient care, "intensive care" and "specialized care," are proposed, reflecting more intensive staffing patterns than currently exist at VSH or in Designated Hospital[1] psychiatric inpatient programs. These new levels of care each will be configured with high staff-to-patient ratios, flexibly scalable environments, and specialized clinical programming. The intensive care service is planned for stabilization of individuals with the most dangerous behaviors. The specialized care service will offer staff-intensive programming, and the longer lengths of stay required by individuals with particularly severe or unresponsive symptoms. The plan proposes to create 50 new inpatient beds at the intensive and specialized levels of care.

New, Residential Recovery and Secure Residential Treatment Programs

The services described below will all be developed by Vermont's network of ten comprehensive community mental health centers, referred to as Designated Agencies.[2] The plan proposes to create two new programs designed to meet the needs of a longer-term care population currently served at VSH but who do not need inpatient-level care. These programs are residential recovery programs for sub-acute rehabilitation, with a capacity of eighteen, and secure residential treatment, with a capacity of six.

The *residential recovery programs* are designed to meet the needs of individuals who have experienced repeated hospitalizations or extended stays at VSH. These individuals often have a slow response to treatment and multiple disabling conditions. With individually focused rehabilitation programming in non-institutional settings, this population can make significant gains towards recovery.

Secure residential treatment programs will be designed to meet the needs of individuals whose symptoms are sufficiently stable to no longer need inpatient care, but who are legally restricted from discharge from a secure setting.

Crisis Beds for Stabilization and Diversion

[1] A designated hospital is a general hospital with psychiatric inpatient services that is designated by the Commissioner of Health (formerly by the Commissioner of Mental Health) to provide treatment to individuals involuntarily committed to the commissioner's care and custody.

[2] A designated agency is a community mental health center designated by the Commissioner of Health (formerly by the Commissioner of Mental Health) as the lead agency to provide comprehensive services to Vermont's priority mental health populations: adults with severe and persistent mental illness, individuals with developmental disabilities, and children and youth with severe emotional disturbances.

The plan proposes to augment the existing network of **crisis beds** for stabilization of an individual's crisis within a community setting and diversion from hospitalization. The goal is to develop programs to help prevent hospitalizations by stabilizing clients in crisis before they reach the clinical threshold for hospitalization. The plan includes developing an additional capacity for 10 new crisis beds, based on a statewide assessment of gaps in the crisis intervention system.

Care Management

The Futures plan includes a *Care Management Program* to ensure that the system can manage and coordinate access to high-intensity services so that Vermonters have access to the appropriate level of care and the system's resources are used efficiently. The system will help to ensure that the most integrated and least restrictive care consistent with safety is being delivered. The care management function will provide service coordination for individuals who cross multiple departmental, institutional and/or mental health program services. This coordination requires the development of common clinical protocols among all partners (designated agencies, diversion providers, designated hospitals, Corrections, etc.), the ability to convey common information for clinical services, utilization management oversight, quality assurance and improvement and conflict resolution. The care management system will create a service network that coordinates the following components:

- General hospital psychiatric inpatient beds.
- Specialized care psychiatric inpatient beds.
- Intensive care psychiatric inpatient beds.
- Residential treatment beds (at different levels of care)
- Crisis stabilization / inpatient diversion beds.

Peer Services, Transportation, Supportive Housing, and Legal Services

The Futures Plan proposes new *Peer Programming*. These services offer effective, recovery-oriented supports. The plan will create new peer support programs targeted to individuals who use VSH. Peers also will be an integral part of the provision of traditional and new services. The expansion of stand-alone peer services will also be explored.

The plan provides resources to create secure, alternative *Transportation* options to the current system of using sheriffs. Additional resources for *Transportation* costs may be necessary as the Futures plan is implemented, due to the geographical distribution of programs.

The plan proposes new *Supportive Housing* resources. The lack of decent, affordable housing has been consistently identified by the Futures Advisory Group as one of the most significant unmet needs of Vermont's citizens with mental illness. There is broad consensus in the stakeholder community of providers, advocates, family members and

consumers that safe and adequate housing is crucial to reducing hospitalization and supporting recovery. Therefore, housing supports will be expanded under the plan.

With inpatient hospital beds distributed in more than one location, this plan identifies the need for additional resources for *Legal Services***,** due to the need for attorneys to consult with clients and witnesses in multiple locations.

Clinical Design Services in this Request for Proposals

The Division of Mental Health (DMH) is seeking clinical design services to develop the **Care Management** component of the Futures Plan. A work group comprised of Mental Health community stakeholders including consumers, clinical leaders, and service providers has met for over a year and developed many of the underlying concepts necessary to create a care management system, such as overall system principles and the rules by which individual patients or clients would move between levels of care. Initial work has also been completed in defining some of the levels of care, clarifying admission criteria, and identifying protocols necessary to operationally implement the care management system.

Key examples of the work to date on the Care Management System design are found in Attachments 1-4 of this RFP.

We seek clinical design services to:

1) Identify options for management structures for Vermont's care management system.
2) Develop consistent documents and protocols for:
   - Descriptions for programs at each level of care in the system
   - Clinical admission, continued stay, and discharge criteria for each level of care
   - The operations of the system (for instance, dispute resolution, census management, and access to emergency screening services).
3) Identify the data elements required for communication of needed clinical information.
4) Create efficient and effective quality improvement, assurance, and utilization management systems.

The design work must be carried out in a collaborative fashion with Vermont's community of mental health stakeholders.

The outcomes of this clinical design work will be:

- A management framework for a care management system
- Consistent policies and protocols to implement the system
- Quality improvement, assurance, and utilization review systems that facilitate continued improvements in the system and effective allocation of resources.

Finally, we expect that these products will be viewed as relevant, appropriate, and useful to service providers such that they are readily used in Vermont.

Schedule

January 29, 2007	Issue RFP
February 12, 2007	Deadline for receipt of letter of intent to bid
February 16, 2007	Bidders Conference, 2:00 – 4:00 Vermont Department of Health 108 Cherry Street Burlington, Vermont
March 5, 2007	Proposals due by 4:30 pm
March 16, 2007	Review Committee meets; presentations by selected bidders
March 23, 2007	Contract negotiations with top ranked bidder
April 27, 2007	Contract executed
May – October 2007	Clinical Care Management System Design
November 14, 2007	Draft Report for Review
December 12, 2007	Final Report

INSTRUCTIONS TO BIDDERS

Proposal Format

Use standard 8.5" X 11" white paper. Documents must be single-spaced and use not less than a twelve-point font. Pages must be numbered. It is required that bidders email an electronic version of the proposal to facilitate proposal reviews and final contract development with the apparently successful bidder.

The program narrative should not exceed 20 pages, excluding Attachments, Required Schedules or Forms.

State your organization's name on each page of your program proposal and on any other information you are submitting.

Proposal Content

Interested individuals should submit their proposal with the following information:

- Applicant's experience and qualifications for performing the clinical design services and documenting these in a final report and the qualifications of assigned staff to this project,
- A description of the approach and methodology to be used,
- Specification of discrete activities to be undertaken
- Maximum hours anticipated for the design activities, broken out by task areas,
- Hourly or project rate for work performed,
- Estimates of other expenses (for example, telephone calls, travel, postage) connected with carrying out the study,
- Total projected costs,
- Relevant supporting material (if any),
- References that can provide information about prior, similar work performed by the bidder.

Letter Of Intent – Pre-Requisite

In order to ensure all necessary communications with the appropriate bidders and to prepare for the review of proposals, one letter of intent to bid must be submitted per bidding agency.

Letters of Intent must be submitted by February 12, 2007 by 4:30 p.m. EST. to:

Beth Tanzman
Division of Mental Health
Department of Health
108 Cherry St.
Burlington, VT 05402-0070
RE: Clinical Design Services for Care Management System

btanzman@vdh.state.vt.us

Delivery of Proposals

Proposals must be received no later than 4:30 p.m. EST on March 5, 2007 at the following address:

Diane Cota
Department of Health
Division of Mental Health
108 Cherry St.
Burlington, VT 05402-0070
RE: Response to RFP – VSH Futures Clinical Care Management System Design

dcota@vdh.state.vt.us

Public Disclosure

All proposals shall become the property of DMH.

All public records of DMH are available for disclosure, except for RFP's prior to the release to potential bidders; and proposals and bids received in response to the RFP, until the Contractor and the Department have executed the contract.

DMH will not disclose RFP records until execution of the contract(s). At that time, all information about the competitive procurement is disclosed except those portions specifically marked by the bidder as falling within one of the exceptions of 1 VSA Sec. 317.

Costs of Proposal Preparation
DMH will not pay any bidder costs associated with preparing or presenting any proposal in response to this RFP.

Receipt of Insufficient Competitive Proposals
If DMH receives one or fewer responsive proposals as a result of this RFP, DMH reserves the right to select a Contractor, which best meets DMH's needs. The Contractor selected need not be the sole bidder but will be required to document their ability to meet the requirements identified in this RFP.

Non-Responsive Proposals/Waiver of Minor Irregularities
Read all instructions carefully. If you do not comply with any part of this RFP, DMH may, at its sole option, reject your proposal as non-responsive.

DMH reserves the right to waive minor irregularities contained in any proposal or to seek clarification from bidding agency.

RFP Amendments
DMH reserves the right to amend this RFP. DMH will mail any RFP amendments to all bidders who sent a letter of intent.

Right To Reject All Proposals
DMH may, at any time and at its sole discretion and without penalty, reject any and all proposals and issue no contract as a result of this RFP.

Authority To Bind DMH
The Commissioner is the only person(s) who may legally commit the Department of Health, Division of Mental Health to personal services, client service, and information service contracts. The Contractor shall not incur, and DMH shall not pay, any costs incurred before a contract is fully executed.

The Department of Health reserves the right to accept or reject any or all bids. The proposals will be evaluated by the staff of VDH and other mental health stakeholders. If an organization is selected, representatives will be invited to negotiate a contract.

Questions Concerning RFP:

Beth Tanzman
Department of Health
Division of Mental Health
108 Cherry St.
Burlington, VT 05402-0070
802-652-2014

Bidder's Conference

There will be a formal bidder's conference for this RFP on February 16, 2007 2:00 - 4:00 p.m. EST, Department of Health, Division of Mental Health, 108 Cherry St., Burlington, VT (telephone 802-652-2014).

Proposal Narrative

1. Organizational Capacity, Experience, and Strength of the Design Team

Please describe your organization and its capacity to provide clinical design services to public mental health systems. Include descriptions of experience that is relevant to the clinical design services described in this RFP. Please identify the design team that you propose including each member's relative contribution to the project and summarize their individual qualifications (resumes should be included in the attachments). Please provide references for your organization's recent work.

2. Scope of Work and Expected Outcomes

Please describe the key activities, methodologies and timeframes that your organization proposes to use to complete the following scope of work and outcomes.

A. Identify Options for Management Structures for Clinical Care Management Systems

How have other public mental health systems (both county and state-level) and managed health care networks designed the management and governance of collaborative systems of care? What is the range of management and governance options and how have these worked to assure access to appropriate levels of care? What are the key pros and cons of the most widely used options? How have some of the more successful approaches been staffed, what do they cost and what is the size and scope of system of care that these models are found in? Which approaches seem most viable for Vermont?

B. Create consistent, written program descriptions for the following levels of care.

Each description should clearly describe the unique role of the program in the Vermont system of care and how it differs from other related levels of care. The program

descriptions should include basic staffing information, core treatment and support modalities provided, and expected client outcomes[3].

- Intensive Inpatient Care
- Specialized Inpatient Care
- General Hospital Inpatient Care
- Crisis Stabilization Bed / Inpatient Diversion Bed
- Recovery Residence at the sub-acute level of care
- Recovery Residence at the secure level of care
- Residential Community Care Services (long term)
- Residential Staff Supervised Group Homes
- Residential Staffed Treatment Group Homes
- Individual Wrap-Around Services

C. Create consistent, specific clinical admission, continued stay, and discharge criteria for each of the levels of care in the program descriptions (in B above).

Each set of admission, continued stay, and discharge criteria should be based on objective observation of clinical status, role functioning, and available support. Vermont has some experience using the LOCUS assessment tool to assist in creating a common language to describe clinical status and to help objectify clinical observations and judgment.

D. Develop uniform protocols to operationalize the following functions and activities in the care management system, based on the overall principles developed.

The following protocols have been proposed for development. These protocols need to be written to apply to any adult client entering the system of care. Each protocol should articulate standards for care with measures to assess whether or not the standard is met.

Standards should also include timeframes for accessing care and client satisfaction / evaluation. The standards should reflect high quality care, even if these cannot be met currently. (For example, no one shall be discharged from the hospital without safe housing). While such standards should exist, they cannot be prescriptive.

Each protocol should be considered from a perspective of how peers could be used to help support better outcomes for clients (for instance peers may assist in communicating the impact of self neglect of medical conditions in a manner that is more powerful than can professionals).

1. Crisis/emergency screening (not just for involuntary treatment)
2. Census management
3. Determination of Safety and Need
4. Transportation

[3] Some of these noted levels of care are more clearly developed and defined than others. The contractor, in consultation with the MH stakeholder community and DMH, may suggest changes to these general categories.

5. System-wide discharge planning for a person not connected to community services.
6. Payment for services for people with no insurance, or for care that is not covered by insurance.
7. Conflict resolution between entities
8. Client rights and dissemination of this information
9. Quality assurance, and improvement for the care management system

E. Identify Design Options for Quality Assurance, Improvement and Utilization Review for the Clinical Care Management System.

In order to be effective, the Vermont Clinical Care Management system requires a quality assurance and improvement system that can identify effective and less effective practices, provide feedback to programs and management on the performance of the system as a whole and identify issues in the allocation of clinical and program resources. In addition, it will require utilization management capability in order to assure that clinical and program resources are used as effectively as possible.

Questions to address include the following. Which approaches to quality improvement, assurance, quality management, and utilization management have proved most effective for collaborating networks of care? How are these staffed? What specific data elements are necessary for effective clinical coordination between different programs and providers? Which are the most impactful and powerful measures to support utilization management and which are the most feasible to implement?

What range of design options seems most appropriate to the Vermont context? Assume that each level of care and service provider will have different information systems and independent systems of management and governance.

How can Vermont fashion a network of collaborating programs and providers with just enough structure, QI, QA, and UR capacity to support collaborative care and the efficient use of system resources? Finally, are there other areas of program design required to create an effective care management system? Please specify and address these in the bid proposal.

F. Staffing Support to the Care Management Work Group throughout the design and development process.

The contractor will interact regularly with the multi-stakeholder Care Management Work Group at its monthly meetings. The contractor will use key informant interviews, program visits and review of documents to assist in the development of work products.

Draft protocols, options for management and governance design, program descriptions etc. will be widely circulated for review and feedback, with final documents incorporating suggested revision.

The contractor will plan and organize meetings of the care management work group and other entities necessary to carry out the design work and will provide documentation of these meetings in the form of minutes and other materials.

G. Final Report detailing System Design and Program Elements

The contractor will provide a final report detailing the products resulting from the scope of work described in this RFP.

3. Proposal Work Plan, Time Frame and Budget

Please provide a proposal work plan to accomplish the scope of work in the time frame described. Identify staff who will be assigned to this project, their roles, and percentage of effort /time devoted to this project. In addition, please provide a budget for the project by major activity. Please describe the fee structure used to develop overall project costs.

PROPOSAL REVIEW

Review Criteria
Proposals will be evaluated using the following general criteria.

1. Experience, organizational capacity to carry out the project, and strength of the design team.

Does the applicant have experience with similar projects? Is the applicant familiar with adult mental health systems of care? Is the applicant familiar with current and emerging trends in managed health and public mental health care? Does the applicant have demonstrated experience in collaborating with mental health community stakeholders including consumers and family members? Does the proposal identify sufficient time and expertise to complete the work within the allotted timeframe? Have team members worked together before?

2. Overall approach to completing the scope of design work.

Does the proposal demonstrate a solid understanding of the technical aspects of the project? Is the approach to developing the design elements specified in "*A"* through *"G"* above comprehensive? Does the proposal reflect a good balance of detailed clinical care design with overall systems design? Is the approach proposed likely to result in practical products that are feasible to implement?

3. Budget / Fee structure.

Is the aggregate fee reasonable yet competitive? Is the hourly rate structure competitive? Are the various rates for specific tasks reasonable, complete and clear?

Review Process
Members of the Division of Mental Health will review proposals for compliance with RFP procedural requirements. If the procedural instructions are not followed, the proposal shall be considered non-responsive. Non-responsive proposals will be eliminated from further evaluation or returned to bidding agency to address minor irregularities.

Proposals will be reviewed for content by a team of individuals from the Department of Health and other Agency of Human Services /Departments with relevant technical, managerial and financial backgrounds. In addition, consumers of mental health services and family members will be included as confidential advisors to the review team.

Scoring

Proposals will be scored by individual team members. The proposal's preliminary score will be the sum of the scores from individual review team members.

The following weight is assigned to each component of the RFP:

	Weight	Maximum Points	Weighted Total
(1) TECHNICAL PROPOSAL	3	20	60
(2) CONTRACTOR QUALIFICATIONS & DESIGN TEAM	3	10	30
(4) PROGRAM COST	1	10	10

Total Maximum Individual Scores 100

Attachment 1
Vermont Care Management System Principles

Vermont Mental Health Futures Initiative
Care Management Workgroup
Subgroup on Client Movement through the System of Care

Principles that Guide the Movement of Clients through the System

1. Clients have an inherent right to choose where to live and/or receive care. That choice may be limited by safety needs of the client and the community, and by the immediate availability of resources.

1.10 Placement decisions or recommendations, and the authority to affect them, reside with and are made by the client-clinician team, starting at the point of establishing a client-provider relationship. Placement decisions resulting from emergency evaluation procedures are based on clinical need.

1.11 Placement or movement of clients observes the principle of using the least restrictive and most integrated settings that are consistent with safety needs. Decisions about placement and commitment of resources follow the spirit and letter of state and federal law as also expressed in the Olmstead ruling.

1.12 Uniform procedures are in place to ensure that as clients enter and move from one part of the system to another, they are informed of their legal status and rights, and receive the necessary assistance to exercise them. Assistance is offered in an atmosphere and manner that supports understanding and thoughtful deliberation about legal issues.

1.13 The receiving facility, program, or clinician has the authority to determine that they lack the capacity to serve a particular client based on factors such as adequacy of skills or resources. When a team turns down a referral, they fully articulate the logistical and/or clinical factors driving the decision, and they remain actively engaged with the other parts of the system in an ongoing decision making process until resolution and placement is achieved.

1.20 The care system requires information technology sufficient to enable operation as a single virtual facility. This includes but is not limited to: one electronic medical record rather than a separate paper record at each physical facility, access across the system to real-time information on resource availability, single-point bed manager function active 24/7, ability to de-identify and aggregate data for outcome studies, and telemedicine for inter-system consultation.

1.21 A uniform plan of care goes with the client through the different levels of care, providing continuity across all settings and over time. Treatment teams change membership to meet the client's needs as clinical situations change. They

include at a minimum the client (or the client's agent) and the clinician(s) involved in ongoing care and/or transfers.

1.22 Access to services and movement between all facilities is timely and based on unified admission/exit criteria, protocols, policies, forms, and referral communications. Transportation is provided in the least restrictive manner consistent with safety.

1.23 The state leads a centralized resource management function for the system that includes the ability to meet critical census demands with temporary emergency placements at facilities in the community. Such central authority is exercised only when teams are unable to come to a decision or resolve a conflict (see conflict resolution protocol) within a time frame that is efficient for the system, safe for the client, and in the best interest of all clients in the system.

1.24 The system is adequately designed to ensure: control by the client or client's agent over who has access to the medical record; protection of the records' confidentiality from private, governmental, or criminal concerns; and prevention of the records' loss from system failures or natural disasters.

1.25 The care management system is designed to include oversight by members of the community, and include the principles of recovery.

2. In the integrated system, risk management is based on shared risk among hospitals, designated agencies, private providers and the state. This is achieved through joint decision making. No one group makes unilateral decisions or assumes risk individually. Reduced risk is a consequence of shared risk

3. The legal process affecting movement of clients functions in a timely manner. Timely hearings serve a client's right to due process and support clinical goals.

4. Managing quality of care is achieved through a system of defined standards, and protocols or guidelines for attaining them. The system measures success at meeting the standards, makes ongoing measurement of deviation from the standards, and provides analysis of the reasons for those deviations. This measurement provides the basis for improving the system and advocating for needed resources. Outcome studies are used to evolve and improve the standards.

Attachment 2
Additional Care Management Design Materials Developed to Date

Inpatient Program Descriptions and Admission Criteria

ENTITIES PROVIDING FEEDBACK:

Care Management System Committee

Docking Station Project – in conjunction with statewide CRT directors

VSH Medical Staff

Designated Hospitals Meeting

Statewide Inpatient Medical Directors Meeting

Hospital & Community Psychiatrists Meeting

Statewide Standing Committee on Mental Health

SYSTEM FUNCTION REPRESENTED:

Vermont's Inpatient Psychiatric Service System

CURRENT LOCATION:

Vermont State Hospital (VSH)

Fletcher Allen Health Care/UVM (FAHC/UVM)

Brattleboro Retreat (BBR)

Rutland Regional Health Care (RRHC)

Central Vermont Hospital (CVH)

Wyndham Center (WC)

FUTURE LOCATION:

Fletcher Allen Health Care/UVM (FAHC/UVM)

Brattleboro Retreat (BBR)

Rutland Regional Health Care (RRHC)

Central Vermont Hospital (CVH)

Wyndham Center (WC)

SECTION A: LEVELS OF SERVICE & THE CARE MANAGEMENT SYSTEM

There shall be three (3) levels of inpatient psychiatric service provided in Vermont:

I. *General Inpatient Psychiatric Services*

II. *Specialized Inpatient Psychiatric Services*

III. *Intensive Inpatient Psychiatric Services*

I. CVH, WC, RRHC, BBR, and FAHC/UVM will provide *General Inpatient Psychiatric Services* (see below)

- CVH and WC will work with patients whom they determine they can be safely manage
  - If CVH and/or WC determine they cannot safely care for a patient, they will be transported to the closest Specialized Inpatient Psychiatric Services hospital
- *All five (5) Designated Hospitals (DHs) are able to apply for commitment; this is therefore not a basis for transfer*
  - *Patients who are treatment resistant/refractory with sustained prominent symptoms and/or low level of functioning may be transferred to Specialized Care Hospitals*
- Qualified Mental Health Professionals (QMHPs) will initially present a potential admission to the geographically most proximate hospital
  - Lack of ability to pay is not a reason for admission outside a DH catchment area
- All five (5) DHs accept warrants
  - *Emergency Examinations certified by a non-psychiatrist when it no psychiatrist is available in the community may go to the local DH*

II. In addition to providing *General Inpatient Psychiatric Services*, RRHC, BBR, and FAHC/UVM will also provide *Specialized Inpatient Psychiatric Services* (see below) on a limited basis

- RRHC and BBR shall take all persons in need of admission from the southernmost 4 counties (name them)
  - Ability to safely contain "intensive" level patients on a time-limited basis
  - RRHC and/or BBR may determine that they are not able to provide adequate care needed for highly acute patients after an initial period of evaluation.
    - In such instances, patients will be transported to FAHC/UVM
  - The only reason for transfers to occur from RRHC and BBR will be for patients that cannot be safely managed (including complex non-psychiatric medical conditions) in an ongoing manner or for assistance with complex diagnostic procedures
- FAHC/UVM shall take all persons in need of admission from the remaining 10 counties (name them)
- RRHC, BBR, and FAHC/UVM shall operate on a "no decline" policy

III. In addition to providing *General Inpatient Psychiatric Services* and *Specialized Inpatient Psychiatric Services*, FAHC/UVM will provide *Intensive Inpatient Psychiatric Services* (see below) on a non-limited basis

- FAHC/UVM will take referrals from RRHC and BBR who are determined to need S*pecialized Inpatient Psychiatric Services* admitted from one of the southernmost 4 counties (name them) after an attempt has been made to assess and manage them.

SECTION B: GENERAL INPATIENT PSYCHIATRIC SERVICES

Admission Criteria for General Inpatient Psychiatric Services:

1. Client must have a diagnosed or suspected mental illness.
2. Client is determined to be one of the following:
   a. danger to self;
   b. danger to others;
   c. unable to care for self;
   d. unable to care for others in his/her care;
   e. in need of 24 hour medical supervision for the treatment of a mental disorder and a complicating medical factor;
   f. in need of rapid evaluation and there is significant risk of deterioration;
   g. in need of medication trials which involve significant risk;
   h. unable to be managed at a lower level of care;
   i. appropriate for lower level of care but no less intensive alternative is available.

Roles Provided By General Inpatient Psychiatric Services:

a) Role #1: Emergency Evaluations (Civil) and Misdemeanants (Forensic)

i) Meets criteria for hospitalization

ii) Assessed not to be too disruptive for the milieu

iii) Likely no prominent history of violence

b) Role #2: Ongoing Treatment (Civil)

i) Acute Stabilization

ii) Meets criteria for hospitalization

iii) Not assessed to be too disruptive to the milieu

iv) Likely no prominent history of violence

v) Likely not a prominent elopement risk

vi) Medication acceptance, or application for involuntary medication pending

vii) Treatment responsive with improved level of functioning

viii) *No prominent aftercare placement issues*

c) Role #3: Court-ordered evaluations (Forensic)

i) Not a prominent public safety risk

ii) Not a prominent elopement risk

SECTION C: SPECIALIZED & INTENSIVE INPATIENT PSYCHIATRIC SERVICES

Admission Criteria for Specialized Inpatient Psychiatric Services:

1. Meets Generalized Inpatient Psychiatric Services admission criteria and one or more of the following:
    a. risk of harm such that there is current suicidal or homicidal behaviors with intention or repeated episodes of violence and/or harmful behavior toward self or others with pattern of nearly continuous attempts;
    b. no natural or community supports available;
    c. multiple recent hospitalizations or prolonged (greater than 30 days) hospitalization;
    d. severe inability to function as demonstrated by:
        i. inappropriate or unintelligible communication
        ii. threatening behaviors with little or no provocation
        iii. total withdrawal from all social interactions
        iv. inability to attend to the most basic daily needs such as personal hygiene, appearance, or nutrition, extreme weight change and extreme sleep disruption causing serious harm to physical/mental health;
        v. evidence of complete inability to maintain any aspect of personal responsibility in the community;
    e. no employment is likely without support;
    f. homeless except for emergency shelter;
    g. significant substance use;
    h. significant involvement with the criminal justice system;
    i. significant medical co morbidity requiring medical monitoring;
    j. stressful community environment as evidenced by traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
        i. ongoing injurious and abusive behaviors from family members;
        ii. witnessing or being a victim of extremely violent incidents;
        iii. persecution by a dominant social group;
        iv. sudden or unexpected death of loved one;
        v. unavoidable exposure to drug use and active encouragement to participate in use
        vi. sustained inability to meet basic needs for physical and material well being;
        vii. chaotic and constantly threatening environment;

k. poor to negligible response to treatment;

l. rarely able to accept reality of illness or any disability which accompanies it, has no desire to adjust behavior, relates poorly to treatment and treatment providers with extremely narrow ability to trust, avoids contact with and use of treatment resources if left to own devices, does not accept any responsibility for recovery.

Admission Criteria for Intensive Inpatient Psychiatric Services:

1. Meets Specialized Inpatient Psychiatric Services admission criteria and poses a risk of harm to self or others requiring 1:1 staffing or more intensive intervention(s) to maintain safety.

Roles Provided By Specialized & Intensive Inpatient Psychiatric Services:

a) Role #1: Conduct Emergency Examinations (EEs) (civil)

i) No room at Generalized Inpatient Psychiatric Services

ii) Too acute for Generalized Inpatient Psychiatric Services

iii) Prominent history of violence

b) Role #2: Provide Ongoing Treatment (Civil)

i) Too Acute for Generalized Inpatient Psychiatric Services

ii) Prominent history of violence

iii) Requires court-ordered involuntary medications.

iv) Treatment resistant/refractory with sustained prominent symptoms and/or low level of functioning.

v) Aftercare placement issues.

c) Role #3: Court Ordered Evaluation (Forensic)

i) Significant danger to self and/or others

ii) Significant public safety risk

iii) Felony or misdemeanor charges

d) Role #4: Ongoing treatment (Forensic)

i) As ordered by the court

ii) Transfers from corrections

Emergency Involuntary Procedures Available at Hospitals Providing Specialized & Intensive Inpatient Psychiatric Services:

- **Emergency Involuntary Medication……YES**
- **Seclusion:**
  - **Locked Door Seclusion in a seclusion room…….....YES**
- **Restraints:**
  - **4-Point……..……YES**
  - **5-Point……..……YES**
  - **Belt & Wristlets…… ……...YES**
  - **Posey Vest Chair for behavior management during a psychiatric emergency…… ……...YES**
  - **Posey Vest Bed for behavior management during a psychiatric emergency……YES**

Non-Emergency Involuntary Procedures Available at Hospitals Providing Specialized & Intensive Inpatient Psychiatric Services:

- **Non-Emergency (Court-Ordered) Involuntary Medication……YES**

Treatment Considerations Provided Through Specialized & Intensive Inpatient Psychiatric Services:

Characteristics of serious mental illness that are important to emphasize because of their crucial impact on treatment include:

1. **Chronicity.** Although not all patients with schizophrenia and affect psychosis develop a chronic course, many do. Chronicity implies that the illness, or the risk of relapse, persists, to some degree, for a longtime-often for the patient's entire life.
2. **Potential for Deterioration.** While people with schizophrenia and affect psychosis can be treated successfully and can make progress, in a deteriorating if the disease is untreated, or if they are repeatedly non-adherent with treatment.
3. **Denial.** Denial is a common characteristic of chronic mental illnesses that may be related, at least in part, to the cognitive deficits associated with the psychotic process. The chronically psychotic patient who cannot accurately perceive the severity of his or her illness is likely not to comply with treatment, and consequently to have a poor outcome.

4. **Disability.** Even when these illnesses are stabilized with medication, significant disability often remains. This disability may be primary, resulting from continuation of symptoms or ongoing deficits in cognitive processing due to the illness; secondary, due to lack of motivation or demoralization resulting from persistent symptoms; and/or tertiary, due to social rejection or stigma as a consequence of exhibiting illness related behavior. All three types of disability or a direct result of the biological disorder and must be addressed for treatment to proceed.

Elements of Care for Specialized & Intensive Inpatient Psychiatric Services:

- Disease Model: Treating the Biological Illness
  1. Make an accurate diagnosis.
  2. Stabilized symptoms pharmacologically.
  3. Assessed baseline functioning.
  4. Relieve patient and family of responsibility for causing the illness.
  5. Mobilize patient and family as allies in managing the illness.
- Psychosocial Component: Treating the Person
  1. Perform a multidimensional, longitudinal assessment.
  2. Educate the patient and family to overcome denial.
  3. Implement a plan to prevent treatment non-adherence.
  4. Help patient and family develop new coping skills.
- Long-term Program of Rehabilitation and Recovery
  1. Maintain long-term stabilization and treatment compliance.
  2. Define attainable "next step" goals and objectives.
  3. Develop a long-term treatment plan to attain these goals.
  4. Address ongoing feelings of impatience and frustration to maintain proper pace of progress.
  5. Help patient and family to maximize self-acceptance, autonomy, and dissatisfaction with life despite persistence of the illness.

In order to create and maintain a system that can meaningfully provide the *Elements of Care for Specialized & Intensive Inpatient Psychiatric Services*, all hospitals providing these levels of care shall:

a) participate in the creation and maintenance of a shared information system in order to facilitate the availability of relevant medical records to inform clinical decision-making;

b) participate in a care management system (outlined in Section A);

   i. participate in the creation and maintenance of a bed management system

c) maintain staffing ratios which permit the use of 1:1 and 2:1 staff to patient coverage when clinically indicated;

d) maintain availability of psychiatrists such that

   i. a covering psychiatrist shall be physically present on the participating unit no longer than 30 minutes after being called, 24 hours a day/365 days per year;

   ii. a covering psychiatrist shall be available to assess and admit (if indicated) new patients 24 hours a day/365 days per year;

e) use common treatment documentation templates including but not limited to

   i. the treatment planning system developed at the Vermont State Hospital & Fletcher Allen Health Care

f) use common clinical protocols including but not limited to

   i. medication formularies

   ii. maximum dose levels

   iii. clinical practice guidelines

   iv. LOCUS scales on all admissions and discharges

   v. LOCUS risk scale as a daily level of risk indicator

g) use common clinical programs including but not limited to

   i. the UCLA social skills training modules

h) use a common Quality Improvement/Utilization Review system

additional notes to be addressed:

>United Health Consoritium (UHC) benchmarks for LOS. Bob justifies this to FAHC.
-can this be adjusted for public pts?
-new edits beyond Medicaid?

>Economic viability of unit, certain % of "non-paying pts" or newly created funding stream for public pts.
-how does Medicaid reimbursement rate factor in?
-what is % of Medicaid-eligible public patients?

>legal system is not organized to help-turnaround time for court proceedings-
-compare all states/ave length of time to medicate

Attachment 3

VERMONT DEPARTMENT OF HEALTH
DIVISION OF MENTAL HEALTH

CLINICAL GUIDELINES FOR PSYCHIATRIC INPATIENT SERVICES: CRITERIA FOR ADMISSION AND CONTINUED STAY FOR CRT (MEDICAID PRIMARY) CLIENTS To GENERAL HOSPTIAL PROGRAMS

Criteria for Admission (if not emergent or urgent)

1. Client must have a diagnosed or suspected mental illness which can be documented through the assignment of appropriate DSM-IV codes.
2. Client is determined to be (one of the following):
   a. A *danger to self*, as evidenced by direct threats or clear inference of serious harm to self, **or**
   b. A *danger to others*, as evidenced by violent, unpredictable or uncontrolled behavior which represents potential serious harm to body or property of others, **or**
   c. *Unable to care for self*, representing potential for imminent serious harm to self, **or**
   d. *Unable to care for others in his/her care ,* presenting a danger to dependents by either action or inaction, **or**
   e. In need of 24 hour medical supervision for the treatment of a mental health disorder with *complicating medical factors,* but which are not the primary reason for admission, **or**
   f. In need of *rapid evaluation* due to complex diagnostic factors in which there is significant risk of deterioration, **or**
   g. In need of *medication trials* which involve significant risk of danger or deterioration, **or**
   h. *Unable to be managed* at a lower level of care, as evidenced by attempts to manage at this level or history of unmanageability at lower levels of care, **or**
   i. Appropriate for a lower level of care but *no less intensive alternative* is available.

Criteria for Continued Stay

1. Client must have a DSM-IV Axis I or II diagnosis that remains the *primary* diagnosis, and
2. Clinical evidence indicates (one of the following):
   a. The *persistence* of problems that precipitated the admission to the degree which continued acute care treatment in an inpatient setting is necessary, **or**
   b. A severe reaction to *medication*, or the need to monitor and adjust medication/dosage that can only be done in an inpatient setting, **or**

c. That *new impairments* or attempts at therapeutic *re-entry* into the community have or would result in exacerbation of the psychiatric illness to the degree that would necessitate *rapid return* to an acute care setting, **and**

3. Client is receiving and participating in active treatment.

Attachment 4
Rules for Change in Level of Care

(This attachment contains both a word document and excel file, they are to be read together)

Introduction
To
Change of Level Criteria

At our last meeting while thinking about the criteria for "admissions" and "discharges" to the various levels of care, I began to wonder if there weren't general principles governing movement within the system – whatever the initial level, and whether the movement was to more or to less intensity.

Not really knowing whether it would be useful or not to pursue this line of thinking (I had suspicions it might just be restating the obvious), I decided to see where it would take me. The result is the attached table.

In some ways it does state the obvious, but there is a surprise in it for me, and two other potential benefits.

I was surprised to see that the table could be a very useful way to monitor the state or health of the overall system. The table essentially characterizes the relationship of a patient with the system - which can be going well as in rule # 11, or very poorly as in rule # 4 or # 18. The quantitative distribution of the system's patients over the rules would tell us how we are doing, and what needs fixing. It quantifies the interaction and flow, rather than simply how much of this or that we have.

The first potential benefit is that it demonstrates the complexity of the obvious, and therefore could be useful in helping clinicians across the system to have a common language to describe a situation and develop goals for it.

Finally the table may foster a conversation that leads to a description of the obvious for all of our experiences, and not just mine.

A Few Notes About Using
The Table

The terms: "Adequate Safety", "Balanced Intensity of Treatment" (not too much, or too little), and "Collaborative Relationship" are left undefined at a systems level. They are defined at an individual patient level by the people intimately involved with the situation: patient, current care provider(s), and potential care provider(s).

The left hand column lists six properties of the relationship between the patient and their care providers. Each logically consistent combination of the presence or absence of that property results in a "rule" numbered 1 to 23. The rule can be read in the attached "Rules" document.

Finally there is the document titled "System Monitoring Notes". This simply lists which rules represent a situation that are not only high priority to fix from a particular patient's point of view, but also from a systemic point of view if the rule represents a large number of people.

Rules

1) Admit patient in appropriate time span, and if necessary with appropriate transportation. (This assumes some people under certain circumstances can be admitted to the highest level voluntarily just as the would be for any other level.)

2) Proposed level should develop plan for admission. Alternative, temporary safety measures should be sought for. System quality monitor should be aware of this deficit.

3) Determine if EE, or non-emergency exam criteria are met, and carry out if necessary. If emergency criteria not met, then consider either continuing at current level or discharge to no care.

4) If EE or non-emergency exam criteria are met, then higher level must discharge another patient or otherwise make room. System quality monitor should give this highest priority for systemic remedies. If emergency criteria not met, then consider either continuing at current level, or discharge to no care.

5) If PPV re-admit in appropriate time span with appropriate transportation. If ONH consider whether or not ONH is necessary for collaboration or not, and admit as in PPV case. If ONH with stipulated EE, proceed as in PPV case.

6) As in rule #2, and when resource becomes available as in rule #5.

7) If PPV, then re-admit in appropriate time span with appropriate transportation. If not PPV determine if EE criteria are met, and carry out if necessary. If ONH with stipulated EE proceed as in PPV. If simple ONH, then file for revocation.

8) If PPV, stipulate EE, or EE, then higher level must discharge a patient or otherwise make room. If simple ONH, file for revocation, and develop plan for admission. System quality monitor should give this high priority for systemic remedies.

9) Utilize collaboration to attempt resolution into either rule 11, or rule 17. If not possible, and safety is not affected by move, then enquire of desired level whether

they will accept patient or not. If safety is affected, and therefore collaboration is lost, then this resolves into rule #3.

10) As in #9, except this will resolve into rule #4 if safety is affected and collaboration lost.

11) No movement necessary – where we hope everybody will be.

12) Attempt to establish collaboration, e.g. more talk or change provider, and resolve into rule #9. If not possible consider continuing at current level, enquiring if higher level will admit, or discharge to lower level or no care if safety not affected. If safety affected, then return to rule #3 or #4.

13) Attempt to re-establish collaboration. If not possible consider continuing or discharging. If safety affected, then return to rule #3 or #4.

14) Utilize collaboration to attempt to resolve into rule 19 or 26. If this is not possible it may necessary to invoke the involuntary mechanisms: PPV, ONH, EE.

15) Very close to #11 – a second sweet spot except one should consider whether the involuntary mechanism is necessary.

16) Attempt to establish collaboration. If there are high numbers of people in this category it may indicate a system relying on coercion in the place of engagement.

17) Do it! Next to #11, we hope everybody experiences this. (This rule assumes a person could e admitted to the highest level voluntarily.)

18) Develop plan to obtain resource. If necessary, develop temporary safety measures. This state could represent a high priority to the system monitor since it could represent mis-use of a high level resource, e.g. stuck in the hospital with no place to go.

19) Attempt to establish collaboration. If not possible, then consider discharge.

20) Do it. Consider whether involuntary status is necessary.

21) Develop plan to obtain resource, and as in #20 consider whether involuntary status is necessary. As in #18 this could be a high priority for the system monitor.

22) Invoke involuntary mechanisms to change level, or establish "collaboration". (Assumes involuntary status can be used to move a person to a lower level, or pen-ultimate levels.)

23) Develop a plan to obtain resource and proceed as in #22. Again may be of high interest to system monitor as in #18 and #21.

System Monitoring Notes

Rules # 2,4,6, and 8 represent dangerous situations and therefore are high priorities to fix.

Rules # 18, 21, and 23 represent potentially wasteful situations and are a high priority to fix.

If there are large #'s of people in rule # 16, this might represent an overly coercive system.

Rules # 11 and 17 followed by 15 and 20 are where the majority of people will be in a well functioning system.

Adequate safety	NO								YES									
Balanced Intensity of Treatment									YES									
Patient is Voluntary	YES				NO				YES				NO				YE	
Collaborative Relationship Exists	YES		NO		YES		NO		YES		NO		YES		NO		YES	
Patient Desires to Change Level	YES				YES				YES		NO		YES	NO			YES	
Resources Available at Current or Proposed Level	Y	N	Y	N	Y	N	Y	N	Y	N							Y	N
RULE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
T = trouble	T		T		T		T				Sweet Spot				Pretty Sweet	? Coercive sys	Next to Sweet	T